Assembly Bill No. 892

Passed the Assembly September 9, 1999

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Chief Clerk of the Assembly

Passed the Senate September 7, 1999

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Secretary of the Senate

This bill was received by the Governor this _____ day

of _____, 1999, at _____ o'clock ____M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Section 1345 of, and to add Section 1368.2 to, the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 892, Alquist. Health care service plans: hospice care.

(1) Existing law requires each health care service plan to provide basic health care services, as specified.

This bill would include, on or after January 1, 2002, as a basic health care service, hospice care that at a minimum shall be equivalent to that provided pursuant to the federal Medicare program, as specified. The bill would require the Commissioner of Corporations to adopt regulations for hospice care, as specified. The bill would require an annual report by the commissioner each January 15th, commencing in the year 2002, of changes in federal regulations that require a change in state regulations for hospice care.

(2) Existing law makes a violation of any provision of the Knox-Keene Health Care Service Plan Act of 1975 a crime. This bill, by increasing the requirements for basic health care services, would change the scope of that crime, and thus would impose a state-mandated local program.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1345 of the Health and Safety Code is amended to read:

1345. As used in this chapter:

(a) ‘‘Advertisement’’ means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) ‘‘Basic health care services’’ means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. ‘‘Basic health care services’’ includes ambulance and ambulance transport services provided through the ‘‘911’’ emergency response system.

(7) Hospice care pursuant to Section 1368.2.

(c) ‘‘Enrollee’’ means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) ‘‘Evidence of coverage’’ means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) ‘‘Group contract’’ means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(f) ‘‘Health care service plan’’ or ‘‘specialized health care service plan’’ means either of the following:

(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of

the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(g) ''License'' means, and ''licensed'' refers to, a license as a plan pursuant to Section 1353.

(h) ''Out-of-area coverage,'' for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan's service area.

(i) ''Provider'' means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) ''Person'' means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) ''Service area'' means a geographical area designated by the plan within which a plan shall provide health care services.

(*l*) ''Solicitation'' means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(m) ''Solicitor'' means any person who engages in the acts defined in subdivision (1) of this section.

(n) ''Solicitor firm'' means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (1) of this section.

(o) ''Specialized health care service plan contract'' means a contract for health care services in a single specialized area of health care, including dental care, for

subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(p) ''Subscriber'' means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(q) Unless the context indicates otherwise, ''plan'' refers to health care service plans and specialized health care service plans.

(r) ''Plan contract'' means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

(s) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters which they purport to present, subject to any specific requirement imposed by this chapter or by the commissioner.

SEC. 2. Section 1368.2 is added to the Health and Safety Code, to read:

1368.2. (a) On and after January 1, 2002, every group health care service plan contract, except a specialized health care service plan contract, which is issued, amended, or renewed, shall include a provision for hospice care.

(b) The hospice care shall at a minimum be equivalent to hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.

(c) The following are applicable to this section and to paragraph (7) of subdivision (b) of Section 1345:

(1) The definitions in Section 1746.

(2) The ''federal regulations'' which means the regulations adopted for hospice care under Title XVIII of the Social Security Act in Title 42 of the Code of Federal Regulations, Chapter IV, Part 418, except Subparts A, B, G, and H, and any amendments or successor provisions thereto.

(d) The commissioner no later than January 1, 2001, shall adopt regulations to implement this section. The regulations shall meet all of the following requirements:

(1) Be consistent with all material elements of the federal regulations that are not by their terms applicable only to eligible Medicare beneficiaries. If there is a conflict between a federal regulation and any state regulation, other than those adopted pursuant to this section, the commissioner shall adopt the regulation that is most favorable for plan subscribers, members or enrollees to receive hospice care.

(2) Be consistent with any other applicable federal or state laws.

(3) Be consistent with the definitions of Section 1746.

(e) This section is not applicable to the subscribers, members, or enrollees of a health care service plan who elect to receive hospice care under the Medicare program.

(f) The commissioner, commencing on January 15, 2002, and on each January 15th thereafter, shall report to the Health Care Service Plan Advisory Committee any changes in the federal regulations that differ materially from the regulations then in effect for this section. The commissioner shall include with the report written text for proposed changes to the regulations then in effect for this section needed to meet the requirements of subdivision (d).

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty

for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 1999

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Governor